

Infusion

Bamlanivimab-etesevimab



PATIENT INFORMATION

Patient Name: _____ DOB: _____

Date: _____ Allergies: _____

Follow-up Provider (if different than ordering provider): _____

Diagnosis and ICD-10: _____

Is the patient in a SNF? No Yes

ORDERS PRECEDED BY A REQUIRE A TO INITIATE THE ORDER.

DOSE:

Bamlanivimab-etesevimab 700mg/1400mg IV ONCE. Administer diluted in 100mL NS with 0.20-0.22 micron filter over a minimum of 31 minutes. Monitor for Infusion reactions.

Qualification/requirements to receive bamlanivimab at Salem Health (if ANY of the following are not answered, the order cannot be processed. For statements allowing for only one yes/no answer, that is the ONLY approved answer to that statement.): Place X inside box for all that apply

Patient has a positive COVID-19 test? YES NO (If the answer is NO, the patient cannot receive this treatment)

- The patient is within 10 days of the onset of symptoms
- Patient weighs more than 40 kg
- Patient is NOT on oxygen therapy or increasing levels of oxygen due to COVID-19

If age is 12 to 17 years: Does the patient have at least ONE of the following? (select all that apply, must select **AT LEAST ONE** to qualify):

- BMI \geq 85th percentile for age and gender (CDC growth charts in links)
- Sickle cell disease
- Congenital or acquired heart disease
- Cerebral palsy or another neurodevelopmental disorder
- Tracheostomy, gastrostomy, positive pressure ventilation or other medical-technology dependence that is NOT related to COVID-19
- Asthma, reactive airway disease or other chronic respiratory disease requiring daily medication

If age is 18 years or older: Does the patient have (select all that apply, must select **AT LEAST ONE** to qualify):

- Age \geq 65
- BMI \geq 35
- CKD
- Diabetes
- Immunosuppressive disease
- Immunosuppressive treatment
- Age \geq to 55 with: CVD
- Age \geq to 55 with: HTN
- Age \geq to 55 with: COPD/other chronic respiratory disease

I have discussed with the patient the contents of the Fact Sheet for Patients, Parents and Caregivers before the patient has received the infusion. YES

I have informed the patient that they should not receive a COVID vaccine for at least 90 days following this infusion. YES

Has the patient been given the Fact Sheet for Patients, Parents and Caregivers (see link)? YES NO

<http://pi.lilly.com/eua/bam-and-ete-eua-factsheet-patient.pdf> (English)

<http://pi.lilly.com/eua/span/bam-and-ete-eua-factsheet-patient-span.pdf> (Spanish)

I have informed the patient that this drug is experimental, and of the risks and benefits of alternative medications/therapies? YES

The patient has given verbal consent to receive bamlanivimab-etesevimab? YES

Pre-meds (drug, dose, and route): (Select ONLY those that apply)

* Patients should be instructed to take oral medications 1/2 hour before appointment*

Diphenhydramine (check one) 25mg IV 50mg IV If not already taken orally prior to arrival

Tylenol 650 mg PO if not already taken prior to arrival

Ondansetron 4mg IV PRN Nausea

Dexamethasone IV _____ mg

Other (drug, dose, route and frequency)

Frequency of Pre-medication ONCE PRN

salemhealth.org

Infusion

Appointment line: 503-814-4638

Fax: 503-814-1465

Clinic Hours:

(M-F: 8 a.m. - 4:30 p.m.,

Sat-Sun & Holidays 8 a.m. - 2:30 p.m.)

PATIENT LABEL

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Patients with central line access:

Select one: Patient has a PICC Implanted port Other CVAD Patient does not have a CVAD

- Central line care per Salem Health CVAD Access Policy. (*Lippincott*). May use alternative dressing or cleanser for skin breakdown.
- Alteplase per Salem Health Central Venous Access Device de-clotting (*Lippincott*) for S/sx of occlusion: Inability to infuse fluids, no blood return, increased resistance when flushing, increased occlusion/high-pressure alarm when using an infusion pump, sluggish gravity flow
- 1 View Chest X-ray to verify PICC tip location PRN for: Catheter migration greater than 5 cm, signs and symptoms of tip malposition (*occlusion unresolved by Alteplase, discomfort in the arm, neck or chest, unusual sensations or sounds when flushing, neck vein engorgement, or heart palpitations.*) Notify Physician or Provider if implemented
- Notify physician if infusion NOT given or patient is a 'No Show' for his or her appointment.
- Follow SH Infusion reaction protocol for symptom of infusion reaction. Notify provider if implemented

Provider Signature

Provider Printed Name

Date: